APPLICATION TO REINSTATE
KENTUCKY DENTAL LICENSE

Office Use Only
Fee Paid _____
Date Paid _____

Date: _____

Print name, as you want it to appear on your license.

Last Name _____ First Name _____ M.I. _____

Name that you retired your license under: _____

KY License Number: _____ KY Specialty Number _____ Area of Specialty _____

KY Anesthesia Permit Number_____

Social Security Number: _____ Birth Date: _____
(mm/dd/yyyy)

Current Mailing Address: _____
Street/Box City State Zip

Address to mail license: _____
Street/Box City State Zip

Daytime Phone: _____ Evening Phone: _____

Current Employer (if applicable) Name: _____ Phone ___ _____

_____
Street/Box City State Zip

Intended place of Practice (if known) Name: _____ Phone _____

_____
Street/Box City State Zip

List all states and the license number in which you hold or have held a license:

State	**License Number**
_____	_____
_____	_____
_____	_____
_____	_____

Have you had any action or mal-practice claims taken against your license, been placed on probation or convicted of a felony in Kentucky or any other state in the past five (5) years? _____ **Yes** _____**No**

If yes, please give place, date and circumstances and send with supporting documents (use additional paper if necessary)

_____

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